DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4166-FN]

Medicare Program; Approved Renewal of Deeming Authority of the Accreditation Association for Ambulatory Health Care, Inc. for Medicare Advantage Health Maintenance Organizations and Local Preferred Provider Organizations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: This notice announces our decision to renew the Medicare Advantage "deeming authority" of the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for Health Maintenance Organizations and Preferred Provider Organizations for a term of 6 years.

DATES: This final notice is effective through July 10, 2018.

FOR FURTHER INFORMATION CONTACT: Abraham Weinschneider, (410) 786–5688; or Edgar Gallardo, (410) 786–0361.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a Medicare Advantage (MA) organization that contracts with CMS. The regulations specifying the Medicare requirements that must be met for a Medicare Advantage Organization (MAO) to enter into a contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare-certified providers and suppliers.

Generally, for an entity to be an MA organization, the organization must be licensed by the State as a risk-bearing organization as set forth in part 422.

As a method of assuring compliance with certain Medicare requirements, an MA organization may choose to become accredited by a CMS-approved accrediting organization (AO). Once accredited by such a CMS-approved AO, we deem the MA organization to be compliant in one or more of six requirements set forth in section 1852(e)(4)(B) of the Act. For an AO to be able to ''deem'' an MA plan compliant with these MA requirements, the AO must prove to CMS that its standards are at least as stringent as Medicare requirements. Health maintenance organizations (HMOs) or preferred provider organizations (PPOs) accredited by an approved AO may receive, at their request, ''deemed'' status for CMS requirements with respect to the following six MA criteria: Quality Improvement; Antidiscrimination; Access to Services; Confidentiality and Accuracy of Enrollee Records; Information on Advanced Directives; and Provider Participation Rules. (See 42 CFR 422.156(b)). At this time, recognition of accreditation does not include the Part D areas of review set out at §423.165(b). AOs that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As we specify at §422.157(b)(2)(ii), the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must apply to CMS to renew its ''deeming authority'' for a subsequent approval period.

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) was approved by CMS as an accreditation organization for MA HMOs and PPOs on July 12, 2006, and that term will expire on July 11, 2012. On December 14, 2011, AAAHC submitted an application to renew its deeming authority. On that same date, AAAHC submitted materials requested from CMS which included updates and/or changes to items set out in Federal regulations at §422.158(a) that are prerequisites for receiving approval of its accreditation

program from CMS, and which were furnished to CMS by AAAHC as a part of their renewal applications for HMOs and PPOs.

II. Deeming Applications Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days after the date of receipt of an application to complete our survey activities and application review process. Within 60 days of receiving a completed application, we must publish a notice in the **Federal Register** that identifies the national accreditation body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish an approval or denial of the application.

III. Proposed Notice

In the March 30, 2012, **Federal Register** (76 FR 19290), we published a proposed notice announcing AAAHC's request for continued CMS approval of its deeming authority for MA HMOs and PPOs. In the proposed notice, we detailed our evaluation criteria. Under section 1852(e)(4) of the Act and our regulations at §422.158 (Federal review of accrediting organizations), we conducted a review of AAAHC's application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

• The types of MA plans that it would review as part of its accreditation process.

• A detailed comparison of the organization's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).

• Detailed information about the organization's survey process, including the following—

++ Frequency of surveys and whether surveys are announced or unannounced.

++ Copies of survey forms, and guidelines and instructions to surveyors.

++ Descriptions of—

—The survey review process and the accreditation status decision making process;

—The procedures used to notify accredited MA organizations of deficiencies and to monitor the correction of those deficiencies; and

—The procedures used to enforce compliance with accreditation requirements.

• Detailed information about the individuals who perform surveys for the accreditation organization, including the following—

++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

++ The education and experience requirements surveyors must meet;

++ The content and frequency of the in-service training provided to survey personnel;

++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

++ The organization's policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.

• A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

• A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

• A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's

standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

• A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the accreditation organization.

• A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.

• A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by CMS.

• The name and address of each person with an ownership or control interest in the accreditation organization.

• CMS also considers AAAHC's past performance in the deeming program and results of recent deeming validation reviews, or look-behind audits conducted as part of continuing Federal oversight of the deeming program under §422.157(d).

In accordance with section 1865(a)(3)(A) of the Act, the March 30, 2012 proposed notice (76 FR 19290) also solicited public comments regarding whether AAAHC's requirements met or exceeded the Medicare conditions of participation as an accrediting organization for MA HMOs and PPOs. We received no public comments in response to our proposed notice.

IV. Provisions of the Final Notice

A. Differences Between AAAHC's Standards and Requirements for Accreditation and Medicare's Conditions and Survey Requirements

We compared the standards and survey process contained in AAAHC's application with the Medicare conditions for accreditation. Our review and evaluation of AAAHC's application

for continued CMS-approval were conducted as described in section III of this final notice, and yielded the following:

• To meet the requirements at §488.10(b), AAAHC modified its policies to include "person(s) receiving hospice benefits prior to completing an enrollment request for an MSA plan" as an exception where an MAO may deny enrollment based on medical status.

• AAAHC amended its crosswalk to ensure current AAAHC standards are clearly crosswalked to the following regulatory requirements: §§422.112(a)(7); 422.118(d); 422.202(d)(1); and 422.204(b)(2).

• To meet the amendments made at §422.156 by the final rule published in the April 15, 2011 **Federal Register** (76 CFR 21498), AAAHC removed Quality Improvement Projects and Chronic Care Improvement Programs from its deeming process.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that AAAHC's accreditation program requirements meet or exceed our requirements. Therefore, we approve AAAHC as a national accreditation organization with deeming authority for MA HMOs and PPOs, effective July 11, 2012 through July 10, 2018.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb)

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare--Hospital Insurance Program; and No. 93.774, Medicare—Supplemental Medical Insurance Program)

Dated: August 9, 2012

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Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

BILLING CODE: 4120-01-P

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